STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085031	A. BUILDING _____ B. WING _____	C 11/30/2018

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SHIPLEY MANOR	2723 SHIPLEY ROAD WILMINGTON, DE 19810

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E 000	Initial Comments An unannounced annual and complaint survey was conducted at this facility from November 27, 2018 to November 30, 2018. The facility census the first day of the survey was 45. During this period, an Emergency Preparedness survey was also conducted by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection in accordance with 42 CFR 483.73. For the Emergency Preparedness survey, no deficiencies were cited.	E 000		
F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from November 27, 2018 through November 30, 2018. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 45. The Stage 2 survey sample size was 21. Abbreviations / definitions in this report are as follows: ADON - Assistant Director of Nursing; CNA - Certified Nurse's Aide; DON - Director of Nursing; LPN - Licensed Practical Nurse; MD - Medical Doctor; RD - Regional Director; RN - Registered Nurse; SW - Social Worker; Activities of daily living (ADL's) - task needed for daily living, e.g. dressing, bathing, toileting,	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/18/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1	F 000		

hygiene;
AM-morning;
Anorexia - loss of appetite;
Anxiety - unpleasant state of inner turmoil, often accompanied by nervous behavior, such as pacing back and forth;
Antidepressant - medication to treat depression;
Antipsychotic - drug to treat psychosis and other mental/emotional conditions;
Ativan - a medication used to treat anxiety disorders;
BBW - (Black Box Warning) warning information on the use of a medication when being used for other than intended use;
BID - twice a day;
Dementia / Alzheimer's Dementia - persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning;
Depression - mental disorder with feelings of sadness or a mood disorder that causes a persistent feeling of sadness and loss of interest that affects how you feel, think and behave;
e.g.-for example;
eMAR - electronic Medication Administration Record - list of daily medications to be administered;
eTAR - electronic Treatment Administration Record - list of daily treatments to be administered;
HS - at bedtime;
Insomnia - inability to fall asleep;
MDD - Major Depressive Disorder;
MDS - Minimum Data Set/standardized assessment tool used in long term care facilities;
mg - unit of measurement;
PRN - as needed;
Psychoactive - drug to treat mental/emotional

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F 000	Continued From page 2 conditions; Psychotic/ Psychosis - loss of contact/touch with reality; Psychopharmacological - medications used to treat mental disorders; Q - every; SW - Social Worker; Trazadone - (oleptro) an antidepressant; Zyprexa - (olanzapine) medication used to treat symptoms of psychotic conditions such as schizophrenia and bipolar disorder (manic depression) Zoloft - (sertraline) medication used to treat depression, obsessive-compulsive disorder and panic and anxiety disorder; # - number sign; 1:1 - one to one.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.	F 561		1/15/19

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F 561	Continued From page 3 §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by : Based on interview, record review, and other facility documentation it was determined that for one (R31) out of 12 sampled residents the facility failed to ensure that bathing is based on the residents preference. Findings include: The following was reviewed in R31's clinical record: 11/26/18 - Progress Note indicated that R31 refused bath. During an interview on 11/27/18 at 2:34 PM, R31 revealed that last evening the CNA came to take R31 for a shower. R31 asked if s/he could take it during the day and the CNA said that there were no slots left on day shift to get a shower. The CNA told R31 that the shower would be marked as refused. R31 expressed a desire to get the shower during the day. 11/28/18 - 3:02 PM - During an interview with E7 (CNA) and E8 (CNA) it was revealed that a schedule for showers is at the front desk. E7 and E8 further revealed if a resident refuses, they ask if the resident wants it at another time.	F 561	1. R31 was discharged on 12/17/2018 as a resident of Shipley Manor. Her bathing preferences were discussed with the resident and she was satisfied with the current routine. 2. All residents receiving assisted bathing have the potential to not have their bathing preferences provided. All residents receiving bathing assistance have been asked (as appropriate) their bathing preferences and it has been recorded. 3. The facility conducted a root cause analysis which will be brought to the QAPI Meeting for review and to accurately record and respect resident bathing preferences. All Nursing staff will be provided in-service education by the Director of Nursing or designee on Residents Rights and care preferences by January 15, 2019. 4. The Director of Nursing or designee will conduct weekly audits randomly to ensure residents preferences are met. Any variance will be reported to the QAPI Meeting for follow-up as needed.	

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F 561	Continued From page 4 11/29/18 - 2:34 PM - During an interview with E5 (CNA) it was revealed that a schedule was used for bathing. E5 further revealed the assignment book that contained the shower schedule was based on room numbers. 11/29/18 - 3:59 PM - During an interview with E2 (DON) it was revealed they use the shower schedule to accommodate the residents. E2 further revealed there is no way they could bathe all the residents on days there is not enough staff. The facility did not have evidence to support the fact that R 31 or other residents are given given showers according to their preference. These findings were reviewed during the exit conference on 11/30/18 at 4:00 PM with E1 (NHA), and E2 (DON), E3 (ADON), and E4 (Regional Director).	F 561		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this	F 582		11/30/18

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F 582	Continued From page 5 section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by : Based on review of facility documentation and interview it was determined that for two (R4 and	F 582	1. R4 and R20 are long-term care residents of Shipley Manor and remain in	

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F 582	Continued From page 6 R20) out of three Medicare Part A discharges reviewed the facility failed to have evidence of a completed Skilled Nursing Facility Advance Beneficiary Notice (SNFABN). Findings include: Review of surveyor requested Skilled Nursing Facility Beneficiary Protection form for three discharged Medicare A residents the following was revealed: 1. R4 started Medicare Part A skilled services on 6/28/18. The last day of covered services was 9/17/18. The resident stayed at the facility as a long term care resident. There was no evidence the facility provided the SNFABN when Medicare Part A services ended and the resident converted to another payer source. 2. R20 started Medicare Part A skilled services on 4/19/18. The last day of covered services was 6/15/18. The resident stayed at the facility as a long term care resident. The SNFABN form signed by the responsible party on 6/11/18 was incomplete. The form did not include include what option the responsible party was choosing for further billing of services no longer provided by Medicare. Interview on 11/28/18 at 11:00 AM with E2 (DON) confirmed that E4 did not have a SNFABN form and that E20's for was incomplete. Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON) and E4 (Regional Director) at approximately 4:00 PM on 11/30/18.	F 582	the facility. 2. Any long-term care resident who completes a skilled-nursing stay under Medicare A has the potential to be effected by not receiving a Skilled Nursing Advance Beneficiary Notice(SNFABN) when they are discharged from Medicare A and return to their long-term payer status. 3. The Social Worker has received education from the State surveyor about the need to provide a SNFABN. The Director of Social Services or designee will audit all long-term care resident discharges weekly for 4 weeks to ensure compliance and then randomly until 100& compliance. 4. Any variances will be reported to the QAPI Meeting for follow-up as needed.	
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii)	F 622		1/15/19

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F 622	Continued From page 7 §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the	F 622		

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F 622	Continued From page 8 facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate.	F 622		

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F 622	Continued From page 9 (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by : Based on record review and interview, it was determined that the facility failed to ensure information was provided to the receiving provider for one (R42) out of the 2 residents transferred to the hospital. The facility failed to include resident care plan goals in the transfer/discharge information. Findings included: R42 was admitted to the hospital on 4/3/18, 8/19/18 and 9/3/18. 11/29/18 1:10 PM - Interview with E3 (ADON) stated that "We don't send out care plan goals when we transfer residents to the hospital." 11/30/18 2:06 PM - Interview with E2 (DON) confirmed that "We do not send care plan goals when we do a resident transfer to the hospital." Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON) and E4 (Regional Director) at approximately 4:00 PM on 11/30/18.	F 622	1. R42 remains a resident of Shipley Manor. Resident is stable and was not effected by this practice. 2. Any resident may be effected by the facility's standard procedure of not including Care Plan goals in the information sent to the hospital. There have been no subsequent requests for care plan goals or hospitalizations since the completion of the survey. 3. The Director of Nursing or designee will in-service Nursing staff on the required information to be sent to the hospital with a resident. Audits of transfer papers will be performed upon transfer by the Director or Nursing or designee for 3 months until 100% compliance is achieved. 4. Any variance will be presented to the QAPI Meeting for follow-up.	
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and	F 623		1/15/19

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F 623	Continued From page 10 the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:	F 623		

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F 623	Continued From page 11 (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.	F 623		

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F 623	Continued From page 12 §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483. 70(l). This REQUIREMENT is not met as evidenced by : Based on record review and interview, it was determined that the facility failed to ensure transfer/discharge information and notifications were provided to the resident/responsible party for one (R42) out of 3 sampled residents. The facility failed to provide discharge/transfer notice that included reason; location; statement of appeal rights; Ombudsman information; and advocacy agencies as indicated. Findings included: Facility policy for Bed-Hold (dated 9/1/18) does not address transfer/discharge notice. Review of R42's clinical record revealed: R42 was admitted to the hospital on 4/3/18, 8/19/18 and 9/3/18. The facility did not have evidence that the required transfer/discharge notices were provided to the resident/responsible party. 11/30/18 2:06 PM - During an interview with E2 (DON) it was revealed that "We do not send that kind of transfer notice with notice of appeal to the resident or responsible party. We send them Bed Hold Authorization Forms during hospital transfers."	F 623	1. R42 remains a long-term care resident of Shipley Manor. 2. All residents transferred to an acute care hospital have the potential to be subject to not providing a discharge/ transfer notice to the resident/responsible party. 3. The Director of Nursing or designee will provide education to all nurses regarding the necessary transfer paperwork required when a resident is sent/ transferred to the hospital January 15, 2019. 4. All transfers to an acute care facility will be review by the Director of Nursing or designee to ensure all required paperwork has been sent. Any variance will be reported to the QAPI Meeting for necessary follow-up.	

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	085031	A. BUILDING _____ B. WING _____	C 11/30/2018

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F 623	Continued From page 13 11/30/18 2:29 PM - During an interview with E5 (MSW) it was confirmed that facility is not practicing sending transfer notices with notice of appeal to resident/responsible party and Ombudsman contact information. Findings were reviewed with E1 (NHA), E2 (DON) , E3 (ADON) and E4 (Regional Director) at approximately 4:00 PM on 11/30/18.	F 623		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483 .10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations . If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F 656		1/15/19

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F 656	Continued From page 14 (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by : Based on record review and interview it was determined that for two (R30 and R3) out of 6 residents reviewed for medication review the facility failed to develop a care plan that addressed behaviors associated with psychoactive medication use, failed to develop specific person centered approaches and failed to develop measurable goals. Findings include: 1. The following was reviewed in R30's clinical record: Care Plans: 7/12/17 (revised 10/31/18) - "I am on a antipsychotic medication with BBW (black box warnings)" with a goal of "The resident will be/ remain free of psychotropic drug related complications, including movement disorder, discomfort,....". Approaches included but were not limited to: -Discuss with MD, family ongoing need for use of	F 656	1. R30 and R3 are both long-term residents of Shipley Manor and remain in the facility. 2. Any resident who has been prescribed psychoactive medication has the potential to be affected by this practice. All Care Plans for residents on psychoactive drugs have been reviewed to ensure they contain person-centered approaches and measurable goals, and updated as needed. 3. The Director of Nursing or designee will ensure that all prescribed psychoactive medications are care planned for interventions and measurable goals by January 15, 2019. The DON or designee will audit all psychoactive medications for Care Plan compliance monthly for 3 months then randomly until 100% compliance. 4. Any variances will be reported to the QAPI Meeting for follow up as needed.	

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F 656	Continued From page 15 medication. Review behaviors / interventions and alternate therapies attempted and their effectiveness as per facility policy. 9/4/17 (revised 10/31/18) - "I have alteration in mood and behavior (refusing care / toileting, verbal outburst / aggression)" with a goal of "I will get the help I need from staff to help cope with behaviors". Approaches included: -Administer medications as ordered. Monitor / document side effects and effectiveness Intervene as necessary to protect the rights and safety of others. Approach / speak in a calm and controlled manner. Redirect. Remove from situation and take to alternate location as needed. -Leave and return later if interventions do not work. 8/3/18 - A quarterly MDS assessment indicated verbal behaviors 1 to 3 days out of 7, rejection of care 4 to 6 days out of 7, use of anti-psychotic and anti-depressant medication daily, cognitive impairment and dementia (Alzheimer's and non-Alzheimer's type). 10/30/18 - An annual MDS documented no behaviors, use of anti-psychotic and anti-depressant medication daily, cognitive impairment and dementia (Alzheimer's and non-Alzheimer's type). 10/30/18 - "I have alteration in mood and behavior due to depression" with a goal of "I will exhibit fewer indicators of depression, anxiety, or sad mood daily or as close to daily as I am able by review date". Interventions included: -Administer medications as ordered.	F 656		

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F 656	Continued From page 16 -Monitor / document for side effects and effectiveness -Monitor / document / report PRN any signs or symptoms of depression including: hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing, negative statements, repetitive anxious or health-related complaints, tearfulness November 2018 - Physician Orders: for two anti-depressants and one anti-psychotic being used for major depressive disorder with psychotic features all originating 8/13/17. R30's care plan lacked personalized interventions and measurable goal / objectives. 11/29/18 2:22 PM - Interview with E2 (DON) the surveyor reviewed the lack of comprehensive care planning. No further information was available. 2. The following was reviewed in R3's clinical record: 9/24/18 - Readmitted to the facility. 9/24/18 - Physicians order for Medication - Zyprexa an antipsychotic medication 5 mg two times a day for dementia with psychosis. Care Plan: 9/24/18 - (revised 9/25/18) - "I am on a antipsychotic medication." with a goal of "The resident will be / remain free of psychotropic drug related complications ....". "Interventions include: Administer medications as ordered by physician; Monitor for side effects and effectiveness q shift; Monitor / record occurrence of target behavior	F 656		

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F 656	Continued From page 17 symptoms (specify); Review for dose reduction if clinically appropriate." 9/25/18 - Review of care plan did not reveal a measurable goal and the interventions did not specify the targeted behavior symptoms for the antipsychotic medication. These findings were reviewed during the exit conference on 11/30/18 at 4:00 PM with E1 (NHA), and E2 (DON), E3 (ADON), and E4 (Regional Director).	F 656		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically	F 758		1/15/19

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F 758	Continued From page 18 contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in § 483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by : Based on record review and interview it was determined that for two (R30 and R3) out of 6 residents reviewed for medication review the facility failed to ensure psychoactive medications were adequately monitored. Findings include: 1. The following was reviewed in R 30' s' clinical record: 8/3/18 and 10/30/18 - An MDS assessment indicated the use of anti-psychotic and anti-depressant medication daily, cognitive impairment and dementia (Alzheimer's and non-Alzheimer's type).	F 758	1. R 30 and R 3 are both long-term residents of Shipley Manor and are stable at the community. The Medication Regimen has been reviewed for both residents and modified to include accurate behavior documentation as it relates to psychotropic medication administration. 2.Any resident receiving anti-psychotics and psychotropic medications for behaviors and/or depression, have the potential to be affected by this practice. 3. Education will be provided to all nurses by the DON or designee on the completion of accurate monitoring for	

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F 758	Continued From page 19 November 2018 Physician Orders: Trazadone 50 mg q 6 hours for depression originating 8/13/17 Zyprexa 2.5 mg hs for MDD with psychotic features originating 8/13/17 Zoloft 25 mg 0.5 mg in am for depression originating 8/13/17 November 2018 Treatment Record (TAR) included the following order to monitor "every evening and night shift document number of behavior episodes, interventions, outcome and side effects" originating 8/9/17: 1=uncooperative 2=angry/agitated 1=redirection 2=1:1 3=see notes 4=prn Side effects... It was unclear from the record how R30 presents with depression and what "psychotic features" were and how they were monitored. 11/28/18 2:09 PM - Interview with E11 (LPN) primary nurse for this resident about behaviors associated with psychoactive medications and how this is monitored. E11 reviewed the eTAR with the above information for monitoring. E11 added that a progress note could be added from the treatment monitoring record. E11 described R 30 as having behaviors as being very difficult to take a shower, screaming and very resistant to any kind of care including getting out of bed. R30 will also get up unassisted at night and "gets into things". 11/28/18 2:24 PM - Interview with E5 (SW) revealed that the social service department does not play a big part in the use and monitoring of psychoactive medications. E5 added that nursing	F 758	continued need and behavioral interventions of psychotropic medication by January 15, 2019. 4. The DON or designee in conjunction with the facility's Consulting Pharmacist will audit the medication regimens and associated behavioral documentation for each resident receiving psychotropic medication monthly for 3 months. Any variance will be reported to the QAPI Meeting for follow-up.	

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F 758	Continued From page 20 does the monitoring. 11/29/18 2:22 PM - Interview with E2 (DON) revealed that R30 has dementia with psychosis that was not well controlled but now that she is on these medications it is well controlled. E2 stated R30 would "kick people, could not go to group activity without disrupting, would come to dining room and turn lights off, if you turned the lights back on R30 would scream at the top of her lungs, she would not take showers. Her daughter used to take her out and she wouldn't go out with her anymore". When asked about how R30 presented with depression E2 stated "daughter very involved visits almost every other day resident would express to her that she was sad, wouldn't talk, wouldn't take treats she used to love that daughter brought in". E2 also confirmed that gradual dose reduction has been tried without success and making another attempt was contraindicated by the doctor over the the last year. The facility was administering psychoactive medication to R30 without clearly identifying and monitoring the behaviors associated with the medications' use. 2. The following was reviewed in R3's clinical record: 9/10/18 - R3 was transferred to psychiatric facility. 9/24/18 - R3 was readmitted to facility. 9/24/18 - An order was written for Zyprexa an antipsychotic medication 5 mg two times a day for dementia with psychosis.	F 758		

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F 758	Continued From page 21 During an interview on 9/30/18 around 10:00 AM with E2 (DON) a request for behavioral documentation was made and revealed the facility was not monitoring behaviors specific to the antipsychotic medication. R3 was receiving antipsychotic medication without identifying and monitoring the behaviors associated with its use. These findings were reviewed during exit conference on 11/30/18 at 4:00 PM with E1 (NHA), and E2 (DON), E3 (ADON), and E4 (Regional Director).	F 758		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by :	F 812		1/15/19

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F 812	Continued From page 22 Based on observations, it was determined that the facility failed to ensure that a container of food product was maintained clean and free of debris, and that staff followed sanitary practices to prevent food contamination. Findings include: 1. Kitchen inspection on 11/27/18 between 9:00 AM and 4:00 PM found the plastic container of food thickener dirty with debris both inside and outside the container, particularly on the upper part of the sliding lid and around the opening of the container. A plastic scoop suspended inside the container in its holder, was also found to have debris on its surface. 2. E12 (Dietary Aide) was observed on 11/27/18 at 10:45 AM, wearing gloves as this staff member was engaged in getting a salad ready for lunch, retrieving bowls and miscellaneous articles. E12 went into the walk-in refrigerator, came out moments later and returned to the work station. E12 then removed the gloves and put on a new pair without first handwashing. E12 was again observed at 10:50 AM putting on a fresh set of gloves without prior handwashing. Findings were reviewed with E1 (NHA), E2 (DON) , E3 (ADON) and E4 (Regional Director) at approximately 4:00 PM on 11/30/18.	F 812	1. The thickener bin and plastic scoop have been cleaned of any debris. 2. All storage containers have the potential to be effected. 3. The Food and Beverage Director will educate all dietary staff about the need for maintaining all storage containers in a clean and sanitary manner. 3. The Food and Beverage Director or designee will audit the dry storage area weekly for 4 weeks and then randomly to ensure all storage is free from debris. 4. Any variance in audit data will be reported to the QAPI Meeting for follow-up . 1, E12 remains employed by Shipley Manor. 2. All Dietary employees are subject to this practice. 3, All Dietary Aides will receive in-service education about the correct procedure for using gloves and hand-washing by the Food and Beverage Director or designee. 4. The Food and Beverage Director or designee will audit hand-washing and glove procedures daily for one week and weekly there after. Any variances will be reported to the QAPI Meeting for follow-up .	

DELAWARE HEALTH
AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care Residents Protection

DEC 21 2018
WILMINGTON

DHSS - DHCQ
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Shipley Manor

DATE SURVEY COMPLETED:
November 30, 2018

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report.		
	An unannounced complaint survey was conducted at this facility from November 27, 2018through November 30, 2018. The deficiencies contained in this report are based on interviews, and review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was one hundred fourteen (114. The survey sample totaled	Answers to 2567 have been submitted electronically. Completion date 1/15/19. Please refer to CMS 2567.	1-15-19
3201	eleven (11).		
3201.1.0	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.2	**Scope**		
	Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.		
	This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed October 25, 2018: F561, F582, F622, F623, F656, F758, and F812.		

Provider's Signature [signature] Title NHA, ED Date 12-19-18